SCHOOL PHYSICIANS' BULLETIN

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VOL. V MAY, 1935 No. 5

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ANNUAL MEETING OF SCHOOL MEDICAL INSPECTORS, HEALTH OFFICERS AND NURSES

The Annual Conference of Health Officers and Public Health Nurses has been called by the New York State Commissioner of Health for June 26-28, inclusive at Saratoga Springs, New York. The headquarters will be at the Grand Union Hotel.

By agreement school physicians will hold their annual convention at the same time and place.

Last year's joint meeting of health participating agencies, was one of the most successful ever held. This year's meeting promises equally as much.

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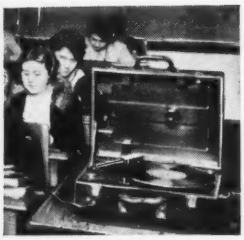

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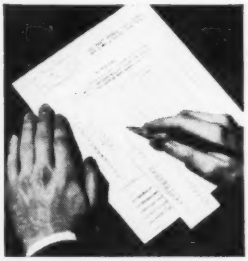

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School Physicians' Bulletin

Devoted to the interests and advancement of School Physicians and the service rendered by them. Your participation by membership is solicited.

VOL. V MAY, 1935 No. 5

EXERCISES FOR SCHOOL CHILDREN WITH HEART DISEASE

SVEN LOKRANTZ, M.D.

Director Health Service Section Los Angeles City Schools

Approximately 6500 children with heart disease are attending the Los Angeles City Schools. The medical supervision of these children has been a problem which has been studied by the Health Department of the city schools for many years.

Twenty years ago no child who took part in competitive athletics had a special physical examination. Children with possible heart defects were assigned to regular physical education classes the same as the physically normal ones. No provisions were made then for a rest period in the middle of the day. Attendance was an important factor. Handicapped children were not allowed to come late to class as they are at the present time, and during the recitation period no special privileges were given. All children returning to school after exclusion because of contagious diseases were assigned to their regular program of physical education. Today these children are given rest periods for one month with special programs of health supervision so that they may benefit physically. Because of the rising mortality of heart disease, special precautions have been taken to safeguard these children. In every way preventive measures are carried out in co-operation with the private physicians.

Heart cases are classified in groups as follows:

Group 1.—Children with purely functional disturbances: Tachycardia of nervous origin (the effort syndrome type). May take part in athletics, with the exception of strenuous activities and competitive games.

Group 2.—Children with minor lesions well compensated: Congenital lesions with no hypertrophy and no disturbance in function. These children are allowed by the school physician to take part in certain exercises in which no extra strain is put on the heart and where the games are very carefully supervised. For example: Golf and certain formal exercises. These children are also given special exercises in the corrective gymnasiums. Exercises are given which will tend to enlarge their chest capacities and indirectly strengthen the heart muscles.

Group 3.—Children with organic lesions moderately well compensated:

a. Valvular diseases of rheumatic origin moderately advanced.

b. Congenital lesions moderately advanced.
c. Certain myocardial impairments.
d. Defective chest development, resulting in poor circulation and defective heart action.
e. Endocrine cases (hyperthyroid).
f. Atonic hearts accompanying malnutrition.

These children are assigned to corrective classes only. They may take part in corrective games.

Group 4.—Children with organic lesions where compensation is poor:

a. Organic valvular and congenital lesions with deficient compensation.
b. Very far advanced lesions with a slight working compensation, but narrow margin of cardiac reserve.
c. Toxic hearts or hearts with otherwise impaired function following recent infections.

These children should have rest only.

All exercises given the children vary in degree and amount of exertion. The exercise groups are divided into different sections: (1) the passive; (2) the active; (3) the imaginary passive; (4) the imaginary active; (5) the imaginary assistive; (6) the imaginary resistive; (7) second and third degree active. For example, a child with minor lesions might be given second and third degree active exercises whereas a child with organic lesions might be given first degree active exercises restive and passive exercises.

To the children of Group 4, with organic lesions where compensation is poor, only passive and assistive exercises are given, with rest before and after.

Many believe that the beneficial effect of exercises on a heart muscle cannot be questioned because the muscle of the heart can be exercised as any other muscle of the human body. As to the harmful effect of exercise on a heart muscle there are many different opinions. Some physicians believe that athletics and exercise in any form are not harmful to a normal heart, no matter how strenuous, with a few exceptions. They claim that a normal heart will resume its normal strength and power no matter how great a strain it has been put to through athletics. Of course a heart that has been damaged through childhood infections can naturally not stand the same amount of exercise and strain as a normal heart.

In exercise I believe that we have one of the greatest therapeutic agents to strengthen the heart muscle and to lengthen the life of a damaged heart. Drugs, of course, are a necessary agent in stimulating and sometimes regulating the heart action. For example, digitalis for a damaged myocardium or quinidine sulphate in paroxysmal tachycardia where exercise would not improve the condition. The study of exercise in the therapeutic aid of heart disease is a field that has not been given enough

attention by physicians and I believe that the future will stimulate a great deal of research in this field for the improvement of heart disease. Of couse exercise alone will never be the only requisite for rehabilitation of the injured muscle. The daily routine and diatetic treatment is of course of great importance in the management of a person with heart disease. Indiscriminate use of exercise in heart conditions may be harmful and the exercises advocated or recommended should be given to fit the individual heart lesions.

Exercise tolerance tests, such as exercises for vital capacity are checked approximately once a week to ascertain the functional capacity of the children and used as a guide of circulatory improvement. Special care is taken that only those exercises are given that will improve the circulation in the veins and improve respiration, thereby decreasing the work of the heart and increasing the amount of oxygen intake.

All exercises, if within a certain limit, tend to exercise the muscle of the heart in a reflex way. Any movement which will in any way interfere with respiration or circulation in the veins is avoided. For instance, hangings, active trunk rolling, forward-lying raising, and sit-lying raising. Chest lifting and respiratory exercises are first to be given in any schedules designed to strengthen the heart muscle.

Herewith are given as examples four schedules, each one assigned to the four groups previously referred to.

Group 1—For children with functional disturbances.

1. Stride standing, arm carrying forward, upward and forward or sideward, downward, three times.
2. Stride standing, arm rolling, two times.
3. Stride standing, head rolling, three times.
4. Deep knee bending, once.
5. Neck firm, side bending right and left, three times.
6. Hip firm, trunk twisting, right and left, three times.
7. Stride standing, shoulder rotation, deep breathing, three times.
8. Rest on back.

Schedule of exercises to be repeated every day.

Exercise tolerance test, once a week.

Group 2—For children with minor heart lesions.

1. Stride standing, arm carrying forward, upward and forward or sideward, downward, three times.
2. Hip firm, trunk rolling in a small circle, three times.
3. Hip firm, knee flexion and extension, once, half knee bending.
4. Stride standing, forearm flexion and extension, seven times.
5. Stride standing, arm flying, slow speed, three times.
6. Arm forward bending, arm stretching sideward and deep breathing, return.

7. Arm carrying forward, upward and forward or sideward, downward, three times.

8. Rest on back before and after ten minutes.

Exercise tolerance test, once a week.

Group 3—For children with organic lesions well compensated.

1. Rest on back fifteen minutes.

2. Lying, arm carrying forward, upward and forward or sideward downward, seven times with deep breathing, imaginary resistive.

3. Lying, knee separation and closing, imaginary resistive.

4. Lying, leg rolling.

5. Sitting, arm rolling, three times.

6. Sitting, double arm flexion and extension with deep breathing.

7. Sitting, head rolling, three times.

8. Sitting, arm carrying forward and backward, three times.

9. Standing, hip firm, side bending right and left, three times.

10. Arm carrying forward, upward and outward, seven times with deep breathing.

11. Rest on back ten minutes.

Exercise tolerance test, once a week.

Group 4—For children with organic lesions with poor compensation.

1. Rest on back fifteen minutes.

2. Lying arm carrying forward, upward sideward, and downward, slowly, with deep breathing, four times.

3. Sitting, chest lifting.

4. Lying, forearm flexion and extension with deep breathing, imaginary assistive.

5. Lying, deep breathing (with air in motion, temperature not over 66 degrees Fahrenheit).

6. Rest on back twenty minutes.

A light general massage will assist the venous flow and might be done by parents under a physician's direction. However, there are heart conditions where massage should not be given; for instance, active heart disease following acute infection.

The purpose of the corrective exercises and rest periods is not to direct the child's medical treatment, but to outline a protective and preventive regimen with regard to physical development. The heart muscle can be exercised with due care in the same way as any other muscle in the body. Medical treatment is left altogether to the discretion of the family physician or the clinic doctor. All questionable heart diseases in children are passed upon by the consulting medical board.

There are several members of this consulting board who meet once a week to aid in diagnosis and to outline the preventive regimen with regard to the general hygiene and nutrition, in so far as these concern the relation of children to the school work. The board does not direct a child's

medical treatment in any way. By this plan great benefit can be accomplished, not only to the child, but also for the school department. The consulting board aims to provide that no child with heart disease shall have its heart reserve taxed or broken. This board also passes upon bulletins which give information as to the general hygiene and the activities of these children in school and at home. It has at its disposal a central place for meeting, sufficient equipment, two stenographers, one social worker, and, by way of instruments, x-ray and fluoroscope, and one electrocardiograph. It has the cooperation of the school nurses, school physicians, corrective teachers, private physicians, and parents.

Several years ago we made a special investigation dealing with the influence of worry and excitement on school children suffering with heart disease, and we found that in such children there is a certain amount of nervous instability. They are extremely sensitive to the remarks of the teacher and their fellow students. Although I have no definite statistics, I found that children with heart defects are injured by school work when teachers are too strict. In such cases leniency is not shown and the child is asked the first question so that the worry of expectancy is avoided.

Arrangements have been made in the city schools of Los Angeles that children suffering with heart disease may come late to class. Sometimes the rest periods are very short, and it would be difficult for them to reach the classroom without hurry. In most schools they are given an opportunity for rest in the middle of the day, upon the recommendation of the family doctor, the school doctor, or the consulting board.

In regard to foci of infection, provision for eradicaton of foci has been made, through inspections by school doctors and nurses, who report findings to the parents to be transmitted to the family physician.

For the past ten years an attempt has been made to work out some definite regimen for the protection and prevention of heart defects among the school children of Los Angels, yet the work is still in its beginning. There is much room for improvement in order to place it on a more scientific basis. It is aimed that this preventive regimen should not interfere in any way with the private physician's medical supervision of the child. From a physical point of view, Los Angeles schools are probably doing more for the prevention and general hygiene of school children with heart disease than is done in most other cities. Los Angeles, however, has no classified educational cardiac classes.

Today many communities in America are beginning to realize the need of special plans for the education of children suffering from heart disease. However, since communities differ greatly, various and flexible methods to be used in meeting human and social problem are needed. The solution of the problem of the education and preventive care for children suffering from heart disease requires the co-operation of the child, the parent, the doctor, and the teacher.

SHOULD CHILDREN GO WITHOUT PROTECTION BECAUSE PARENTS NEGLECT THEM?*

ERNEST A. COOK, M.D.

School Physician, Pontiac Public Schools

We do not believe that anything should be done by school health departments which would interfere with the income the private physician derives from his practice. Our work should be educational. Having educated the public to the value of a preventive remedy, its administration should be turned over to the family physician. In fact, many of us may some day be in private practice and it would be foolish of us to establish a system in our schools which would affect our incomes in the future. Yet we believe that the health of the children should be considered first.

Diphtheria toxoid (or toxin-antitoxin) was given in our schools for about ten years. It would seem that this was long enough to demonstrate its value to the public so that parents would be glad to take their children to the family doctor for immunization. But let us see what happens when it is no longer given in the schools.

Four years ago our County Medical Society requested us to give no more toxoid in the schools. They generously offered to give it to any school child "at a price agreeable to the parents" if they were not able to pay the usual fee. There is therefore no reason why any child cannot be immunized if his parents desire it.

In February, 1935, a questionnaire was sent to each physician in the city to determine the number of school children who had received toxoid during the year 1934. The total amounted to approximately 380, including a few given by the City Health Department. We formerly gave it to about 1,500 per year in the schools (in 1928—2,488). We estimate that the total in our schools who have received toxoid has decreased from over 60 per cent to little over 40 per cent.

Considering the offer of the physicians and the fact that our City Health Department offers toxoid to any child whose parents will bring him to the office for it, the only persons responsible for their children's not being immunized are the parents. They have been educated as to its value and there is no financial reason why they cannot have it, but they just neglect to have it done. Should the children go without protection because their parents neglect them?

We are led to believe that the only way at present to get a fairly high per cent of children immunized is to have it practically forced upon them at school. The value of smallpox vaccination has been known for over a hundred years, yet consider the small number of parents who will take time to have it done. We should, however, co-operate with the private physicians and hand the work over to them whenever any method is found by which they can immunize a fairly high proportion of the children.

*Bulletin of the Michigan Association of School Physicians.

DR. HENRY D. CHADWICK SAYS

In a recent issue of *Contact,* published by the Massachusetts State Department of Public Health, Dr. Henry D. Chadwick, State Commissioner of Health, says:

"There is a great need for standardization of the school medical service. A State association of school physicians, or State-wide planning in some way by school physicians should be undertaken, the objective to be improvement of school medical service. Uniformity of practice should be worked out as to what are defects; what degree of defect warrants the expenditure of the nurse's time to obtain correction; whether defects of vision and hearing should receive a greater expenditure of time and energy on the part of the teacher, the nurse, and the physician for their correction than for the removal of tonsils, whether mere size or appearance of a tonsil should be the criterion for reference to a physician for operation or whether absences from school because of colds or sore throat or rheumatic pains or malnutrition should be the determining factor. With so much to do and so few to do it, the school medical staff must discriminate and do first things first. They must select the conditions that are the greatest handicap and concentrate their efforts on the correction of those that retard the child's physical and mental progress. The school medical service should be evaluated not on the number of physical defects found but on the percentage of major defects corrected. I hope that 1935 will show noteworthy progress along these lines."

SCHOOL SUPERINTENDENTS DEVOTE THEIR PROGRAM TO HEALTH PROBLEMS

The Old Colony Superintendents' Association of Massachusetts devoted its March meeting to a discussion of health problems with the following program:

Instruction in Healthful Living—Content and Method. Dr. Zenos Scott, President, State Teachers College, Bridgewater.

Some Methods of Evaluating the Health Education Program. Fredrika Moore, M.D., Consultant in School Hygiene, Massachusetts Department of Public Health.

Physical Education—Its Function in Health Education. Mr. Carl L. Schrader, Supervisor of Physical Education, Massachusetts Department of Education.

How One School Handles the Problem of Health Instruction. Miss Elizabeth H. Sampson, Principal, Hedge School, Plymouth.

Summary. Mr. Charles W. Lawrence, Superintendent of Schools, Kingston.

Comment.—This is good team work. More of such is greatly needed. More strength to school authorities for such an integrated program.

SCHOOL PHYSICIANS ORGANIZE IN MASSACHUSETTS

The school physicians of the Essex South District met at Beverly, Mass., January 16, 1935 for the purpose of forming a permanent organization. The following officers were elected: Dr. Whitman G. Stickney, President; Dr. Ellis Michelson, Lynn, and Dr. E. C. Steeves, Essex, Vice-Presidents; and Dr. Howard K. Glidden, Swampscott, Secretary-Treasurer. Dr. J. G. Corcoran, Hamilton, Dr. James A. Clark, Saugus, and Dr. Samuel C. Eveleth, Marblehead, were named as Executive Committee—this committee to work with the major officers. Dr. Charles F. Deering, Danvers, Dr. Oliver E. Bixby, Lynn, and Dr. Katharine C. Sheehan, Salem, were elected Publicity Committee.

Mr. Starr M. King, Superintendent of Schools, Beverly, spoke on the "School Health Program from the Viewpoint of the Superintendent."

The next meeting will be held at Lynn on May fifteenth.—*Contact.*

Comment.—The organization of school physicians is rapidly moving forward in Massachusetts, under able leadership.

Its recommendation by the State Commissioner of Health and approval by school authorities, insure its success.

The American Association of School Physicians congratulates Massachusetts on this effective unification of forces, for the promotion of child health. We welcome the new organization to the needed mobilization of the medical profession, for greater efficiency and leadership in this vital phase of public health.

WESTCHESTER COUNTY (N. Y.) TEACHERS' ASSOCIATION PRESENTS HEALTH PROGRAM

At the Annual Spring Convention of the Westchester County (N. Y.) Teachers' Association the following health program was presented:

Chairman: Dr. Elton G. Littell, Medical Director, Public Schools, Yonkers.

Address: "Health Program in the Schools," Dr. Dean F. Smiley, Director, Health and Physical Education Division, State Department of Education.

Address: "Conservation of Hearing"—A resume of the work now being done in Westchester County for the Hard of Hearing Child. Dr. Emily A. Pratt, Supervisor of Eyes and Ears, State Department of Education.

Cooperating in this section are:

(1) School nurses and physicians.
(2) Parent-Teacher Associations.
(3) Representatives of Boards of Education and School Administration.

Comment.—Another splendid recognition by teachers of the importance of health in any school system. A good example for others to follow.

MILWAUKEE ASSOCIATION OF SCHOOL PHYSICIANS

ELEANORE CUSHING-LIPPITT, M.D.

Chairman, Committee on Education—Including Publicity

The recently formed Milwaukee Association of School Physicians held a luncheon meeting on Tuesday, March the sixth, at which the Health Commissioner, Dr. John Koehler, and Dr. George P. Barth, Director of the Division of School Hygiene of the Health Department, were guests.

Dr. Koehler spoke on the scarlet fever situation; he showed that Milwaukee's plan of barring children under seven from schools and other public places had tended to lessen the incidence of the disease. It was still too early, he said, to show that it also lessened the incidence of measles, since the ban had been in operation but a short time, and the incubation period of the latter disease is a long one.

Dr. Koehler commented favorably upon the state objects of the association, which are, briefly:

1. To improve school medical service for the children of Milwaukee.

2. To make school medical service a greater aid to the Health Department of Milwaukee.

3. To further the relations between the school physicians and the other medical practitioners of Milwaukee.

4. To advance and improve the status of school physicians.

Dr. Barth gave a history of the development of school medical service in Milwaukee, showing improvements thus far effected, and sketching desirable changes for the future.

The President, Dr. Leander Stamm, announced that the executive committee, consisting of Drs. J. W. Hansen, E. B. O'Leary, H. A. Pfeiffer, with Dr. Edward Jackson as chairman, and the president and secretary-treasurer as members ex-officio, would meet once a month to formulate plans for the approval of the association as a whole. It was also announced that Drs. J. H. Reynolds, J. F. Shimpa and S. E. Kohn had been appointed members of the Committee on Education, with Eleanore Cushing-Lippitt as chairman.

The formation of an association of school physicians in Milwaukee at this date is timely, inasmuch as the American Association of School Physicians will hold its annual convention here in October in conjunction with the American Public Health Association.

A number of our Milwaukee school physicians are members of both above-named national organizations.

April 2, 1935.

Hotel Astor, Milwaukee, Wis.

INFANTILE PARALYSIS ENTERS THE BODY THROUGH THE OLFACTORY NERVE

New evidence that the virus of infantile paralysis enters the body through the nose, traveling *via* the olfactory nerve, the nerve of smell, has recently been reported in *Science*.

Monkeys have been found to develop the disease of infantile paralysis promptly when the virus was placed inside the nose or swabbed on the membranes lining the nostrils. Examination has indicated that the olfactory nerve is the route to the brain. In monkeys whose olfactory nerve had been cut the virus could not find its way to the brain and they remained healthy and did not develop paralysis.—*W. Good Health.*

POLIOMYELITIS SYMPTOMS

Summer time is poliomyelitis time routinely in Nassau County. While there is no indication for fearing an epidemic, we can be certain that a few cases will appear and to insure the best possible chance for recovery prompt recognition of the disease is essential.

We are indebted to the Bulletin of the Los Angeles County Medical Society for the following brief outline of Poliomyelitis Symptoms:

Incubation Period: Rarely less than 6, nor more than 18 days, usually 7 to 14 days.

Types of onsets: Much the same in all types. May be just as severe in the abortive and non-paralytic as in paralytic. Vast majority of cases abrupt. Rarely insidious (cold). Three (3) types on onset: (1) Out-of-the-blue paralysis—rather rare. (2) Systemic infection gradually and uninterruptedly involving the central nervous system. (3) Dromedary type.

Symptoms: Headache (constant) Fever (constant) vomiting, constipation (diarrhea).

Fever: No characteristic curve; lasts 4 to 10 days; falls by lysis occasionally by crisis.

Pulse: In the proportion to fever. Rapid rate—Bulbar paralysis.

Respiration: With pulse and temperature. Rapid rate—Bulbar involvement.

Hyperaesthesia: More diagnostic as an early symptom even than the fever; may be quite general and elicited by lightest touch or deep pressure; more marked over spine and large nerve trunks. Hyperaesthesia and anaesthesia practically never occur.

Pain in neck.

Extreme drowsiness: Alternating with irritabilty when disturbed. Pain in extremities presages an oncoming paralysis. Neuritic pains common.

Tremor or twitchings of muscle groups, occasional early symptoms.

Convulsions: Rare—in more recent epidemics.

Meningeal symptoms: Occurring early are anterior-posterior.

Stiffness of neck and especially of the back
Often a moderate Kernig's sign
Positive Brudzinski's sign.
Positive MacEwen sign
Changes in reflexes
Profuse sweating often an early symptom.

Classification of Poliomyelitis:

1. The spinal poliomyelitis form.
2. The meningitic.
3. The encephalitic.
4. The form resembling Landry's paralysis.
5. The abortive.
6. The bulbar or pontine form.
7. The ataxic.
8. The polyneuritic (resembling neuritis).—*Nassau News.*

REULTS OF 500 DICK TESTS IN ONE ELEMENTARY SCHOOL

RICHARD W. WEISER, M.D.
Medical Supervisor, Kenmore, N. Y.

With more evidence of the reliability of the Dick Test in the literature in the past year, I was promped to make a check on one of our elementary schools in which eight scarlet fever cases, all in different rooms, appeared in January.

As an example of some of this evidence we see in the *Journal-Lancet,* May 15, 1934, page 289, Dr. Gladys H. Dick reported 24,000 persons spontaneously negative to the Dick Test, who passed through several epidemics without contracting scarlet fever. Also records of 4,000 pupil nurses and internes with spontaneously negative skin tests who were continuously on duty in scarlet fever wards without immunization, show that none of these people contracted scarlet fever. Reports of this type are becoming more frequent daily and should help to dispel the lack of faith that so many physicians have in the Dick Test.

The method of procedure adopted in this school was to send a letter to every parent, describing the Dick Test and its purpose and ask their permission to make the test. After the test was made a follow-up letter was sent to parents giving the result of the test and, in the case of positive reactors, the parents were advised to have their children receive the 5 immunizing doses by their family physician.

Five hundred and four responded with their permissions out of a possible 700. Of the 200 who returned their letters with "No," a large number gave as their reason that on calling their family physician, the latter recommended the Dick Test should not be made. The remaining number were those who had scarlet fever previously and did not think

the test necessary. The results of the tests showed that 214 were strongly positive; 140 mildly positive and 150 negative. This gave a percentage of 70.2% positive and 29.8% negative. The skin test technique was very exacting. The mildly positives were listed under those with a skin reaction of the slightest flush or redening, if they measured as much as ten millimeters in any direction. In addition to the 504 students whose ages ran from 5 to 12 years, 23 teachers of varying ages from 23 to 50 years were tested. Of these, 5 were strongly positive, 3 mildly positive and 15 negative. Of the negatives, 1 had received the immunization course three years ago by Dr. Gladys Dick in a Chicago nursery school, and 4 had scarlet fever previously. It is interesting to note that after the special program of Dick testing was started February 1, 1935, the number of cases dropped from 8 in January to 2 in February, 1 in March and none in April. The 2 that occurred in February were not previously tested and the 1 who contracted scarlet in March had astrong positive reaction to the Dick Test in February. In order to create greater interest in the Dick Test among the children a button system was adopted. All the strongly positives and the students who returned their letters with "No permission" on them were given red buttons to wear. The mildly positives were given yellow buttons and the negatives were given blue buttons. The students were told that the blue buttons were the most desirable ones to have, and that they could have their yellow or red button changed to a blue button with a gold star on it if they would bring a letter from their family physician certifying that they had completed the 5 immunizing doses against scarlet.

With the above knowledge of susceptibles and non-susceptibles I had the teachers rearrange seating in their rooms so that no two red buttons sat next to each other; nor were the red buttons allowed to pair up and play with each other in school. Educational projects were made with the buttons by having the red buttons oppose the yellow or blue in spelling bees and arithmetic contests.

To date I have had a return of 35 letters from physicians certifying that certain children had completed the immunization course against scarlet fever. This is not a large number but it is particularly encouraging for a cummunity where the majority of the local physicians are hesitant in recommending the immunization to their patients. My daughter and I were each strongly positive to the test. We took the five immunizing doses and were not incapacitated at any time from the reactions. The same story was true to many others who took the immunization course.

Out of the total number of 700 replies to our letters we learned that 79 of these had scarlet previously. Of the 79, 36 refused to have the Dick Test. Dick Tests on the remaining 43 brought out the following very interesting results: 24 were negative to the Dick Test, 15 were

mildly positive and 4 were strongly positive. I was able to contact personally 3 of the parents whose children were pronounced positive and in all 3 I received a similar history such as follows: That they were quarantined 30 days with a diagnosis of scarlet, but that at no time had the children vomited; temperatures were under 100, throats moderately sore and rashes that lasted only 12 hours. All of these cases looked like ones of mistaken identity in view of the Dick Test findings or they were questionable mild cases of scarlet.

With these Dick Test results I was able to answer the question which several parents have asked me, "Why did my child have scarlet fever twice?" These results are also a good reason why every person in the school should receive the Dick Test regardless of whether they had scarlet before.

In conclusion, I believe we have a very powerful weapon in the form of the Dick Test and the scarlet fever immunizing toxin to be used in the eradication of scarlet fever from our schools.

MILWAUKEE SCHOOL PHYSICIANS ORGANIZE

The American Association of School Physicians is greatly pleased to note, as published elsewhere in this number of the Bulletin, the recent organization of the school physicians in the city of Milwaukee.

The purposes of the organization are sound and well defined.

Prominent health workers, already engaged in the service, are leaders in the movement.

Its success is certain and many more such and larger organizations are needed. Others are already contemplated. Organization for medical leadership in school health service is rapidly moving forward. More strength to the medical profession to promote its advancement.

We welcome Milwaukee to the organized group, and extend our hearty congratulations.

EPILEPSY AND HEREDITY

"The popular conception of an inherited deteriorating personality as the underlying cause of epilepsy has resulted in great misunderstanding and injustice both to the patient and to his family. The fear, prejudice and even aversion which a person with epilepsy so often encounters when seeking education, employment or entrance into social activities can be attributed in considerable measure to such an attitude toward the disease. It is not uncommon to encounter families of excellent stock who dread to have the children they desire, because of the possibility of transmitting to them the taint of epilepsy. A family skeleton of epilepsy is a social disgrace."—EDWARD M. BRIDGE, M.D., from article in Archives of Neurology and Psychiatry.

NEW ENGLAND HEALTH EDUCATION ASSOCIATION ANNOUNCEMENT

The Jubilee Meeting of the New England Health Education Association will be held Friday, May 31 and Saturday, June 1, at the Massachusetts Institute of Technology, Cambridge, Mass.

The programs contains much of special interest. For program reservations and further information, apply to the Secretary, Mrs. John Fuller, Massachusetts Institute of Technology, Cambridge, Mass.

The public is most cordially invited.

SCHOOL HEALTH BIBLIOGRAPHY*
With Annotations

"Physical Diagnosis," Richard C. Cabot. Eleventh Edition. Baltimore, William Wood and Co., 1934. 540 pp., illust. 8vo. Cloth $5.00.

This book is already widely known. Little more need be said of this volume except that it supplies the physician with a brief but valuable guide for examining the human body.

"Co-operation—Its Nature, Evaluation and Practice," S. A. Courtis, Professor of Education, University of Michigan. Brumfield and Brumfield. 77 pp.

A splendid treatise on a subject about which every social worker need know more.

"Clinical Significance of the Systolic Murmur. A Study of 1,000 Consecutive 'Non-cardiac' Cases." A. R. Freeman and Samuel Levine. Ann. Int. Med. 6:1371 (May) 1933.

A splendid clinical discussion of a topic of real interest in preventive medicine and school health.

"The Child: His Origin, Development and Care." Florence Brown Sherbon, M.D. New York: McGraw Hill Co., 1934. 707 pp. Price $3.50.

A comprehensive discourse on the child which should be read by every student of child health.

"The Theory of Play." Elmer D. Mitchell and Bernard S. Mason. New York: Barnes, 1934, 547 pp. Price $2.80.

Play is an important part of healthy living. This book clarifies for the reader the part play offers the individual in achieving certain psychological and physical satisfactions in life. It offers the school physician considerable insight into the problems confronting the physical educator.

"A Decade of Progress in Eugenics," Scientific Papers of the Third International Congress in Eugenics, held at the American Museum of Natural History, New York, August, 1932. Published by Williams and Wilkins Company, 1934. 531 pages. Price $6.00.

A valuable collection of papers for the person interested in problems of race betterment.

*Prepared by Earl E. Kleinschmidt, M.D., Ann Arbor, Michigan, Associate Editor.

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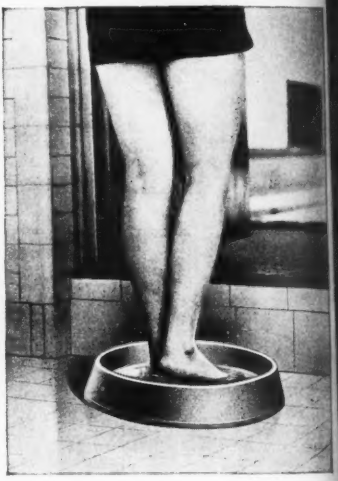

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